DOCUMENT RESUME

ED 036 836 CG 005 048

AUTHOR Fraknoi, Julia
TITLE Changing Attitudes in Underprivileged Adolescents Participating in Group Psychotherapy.
PUB DATE Nov 69
NOTE 11p.; Presented at the World Mental Health Assembly, Washington, D. C. November 17-21, 1969

EDRS PRICE EDRS Price MF-$0.25 HC-$0.65
DESCRIPTORS *Adolescents, *Changing Attitudes, *Emotional Problems, *Group Therapy, *Socially Disadvantaged

ABSTRACT

Group psychotherapy was used with socio-economically deprived adolescents whose capacity for self-expression was promising. Non-psychotic acting out characters and passive inadequate personalities participated, and discussion, role playing, and psychodrama were the techniques utilized. After one year the following changes were seen: (1) increased reliance on verbalization as an alternative to action; (2) a beginning awareness that rigid attitudes can be modified; (3) increased trust toward the therapists, (4) growing interest and consideration toward group members; (5) increased self-respect; and (6) more realistic super-ego attitudes. Various behavioral manifestations and changing attitudes gave rise to some theoretical constructs regarding dynamic configurations and therapeutic results. It was presumed that passivity as well as destructive acting out behavior can be explained on the basis of a negative self-image defended against either by denial (of the need for or loss of gratification) and identication (with the aggressive "bad" introject or with the weak "good" introject. Therapeutic intervention amid at strengthening the "good" introject and weakening the "bad" introject resulted in the modification of the defense configuration and the liberation of mental energies formerly unavailable for constructive purposes. (RSM/Author)

Presented at the 1969 World Mental Health Assembly, in Washington D.C.

Julia Fraknoi, Ph.D.*

ED036836

CHANGING ATTITUDES IN UNDERPRIVILEGED ADOLESCENTS PARTICIPATING IN GROUP PSYCHOTHERAPY

INTRODUCTION

In a newly established Community Mental Health Clinic servicing a socio-economically deprived, predominantly Negro population, group psychotherapy has been used as the treatment of choice with adolescents (ages 13-16) whose capacity or potential for self-expression is promising,

A. whenever the reason for referral and subsequent diagnostic studies indicate the need for at least some degree of insight in order to bring about changed attitudes, yet the chances for successful individual treatment seem rather slim, while they are expected to benefit from meaningful therapeutic peer interaction; or

B. when after having been treated in the Clinic individually, they need to be "weaned" from individual therapy.

(Reasons for referral range from school problems to mild delinquency, sexual acting out, suicidal threats, etc., etc.)

Other criteria:

Personality:

Both aggressive acting out characters and passive, inadequate personalities are acceptable but, preferably, the former should be the younger and the latter the older ones.

Degree and Quality of Pathology:

Non-psychotic, character disorder, inadequate personality (mild ego weakness), adjustment reaction, neurosis, etc.

CG005048

*Director of Psychological Services, Philadelphia Psychiatric Center Community Mental Health Clinic; Associate in Psychology in Psychiatry, Medical School, University of Pennsylvania; Consultant, Child Study Center of Philadelphia

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

Intelligence

Minimum I.Q. 80, no upper limit

Group Structure

Group Leaders:

Therapist and assistant therapist (adolescent who "graduated" after having been member of a similar treatment group.)

Method:

Discussion; role playing; psychodrama

Frequency:

Once a week 1.5 hour sessions

Size of Groups:

5-10

Treatment Results

Assessed over a one year period of group therapy they can be summed up as (1) somewhat increased reliance on verbalization as an alternative to action; (2) a beginning awareness that rigid positions (attitudes toward parents, authority figures, peers) can be modified, and that one might weigh and deliberate over the merits of various approaches; (3) more or less well established trust toward therapist and assistant therapist with an almost total absence of transference phenomena; (4) growing interest in and considerateness toward the other group members in patients who were previously considered (and considered themselves) egotistic and demanding; (5) increased self-respect because of the latter and also because of the group members' awareness of their usefulness to each other; (6) more realistic super-ego

attitudes due to the fact that group members were not castigated for their occasional acting out behavior but, rather, attempts were being made to understand why they did what they did and what could have been the alternatives in the given situation.

THEORETICAL CONSIDERATIONS

Various behavioral manifestations and, more specifically, the general trends and charging attitudes in the group sessions, gave rise to some theoretical constructs regarding dynamic configurations, and therapeutic results.

Diagram 1 attempts to account for the frequently experienced improvement in a patient's behavior and fading out of symptoms in the initial stage of treatment when not enough therapeutic work has been done yet to "justify" it. On closer observation one often finds that this kind of improvement without change (i.e. without, and prior to, the acquisition of new attitudes) could be appropriately described as increasing frequency of the patient's functioning on the higher, rather than the lower levels of the initial range of behavior.

Our first formulation of therapeutic changes (Diagram 2) concerns itself with movement (on the horizontal line) from, in extreme cases, a position of excessive passivity to increasingly active attitudes in the area of verbalizations as well as in actual performance, school, job, involvement with people, etc. The movement along this horizontal line, however, must also be appraised in terms of the other dimension, with the vertical line representing attitudes ranging from extremely destructive to wholly constructive ones. In dynamic terms one might understand, hypothetically, destructive attitudes as manifestations of

negative feelings toward the "object" (reaction to and identification with the depriving aspects of the "bad mother") while constructive attitudes could be perceived as manifestations of the wish to preserve, and identify with the "object" (the "good mother.")

Thus, in a hypothetical case, the patient might move (counter-clockwise) from orally clinging attitudes to passive-aggressiveness (or vice-versa) and as his activity level increases he might, first, act out hostile (destructive) impulses in any combination of oral, anal and phallic aggressive trends before (probably as a result of both increased awareness of just why and what he is trying to do as well as an increasingly positive attitude toward the "object" and resulting improved self-image) he can experience a real sense of mastery, hence pleasure in and motivation for constructive activity, concerned involvement and free communication with people.

Just to mention two instances of transition from passive-aggressive to active aggressive attitudes, one of the group members remained silent during the session, but usually managed to make some rather cutting, critical remarks after the session in a one to one situation with the therapist. Another group member, too, seemed to prefer to remain passive, yet on the one occasion when in a psychodrama he was offered the role of the foreman of the jury, he came out to everybody's surprise with a "guilty" verdict and suggested that the defendant be sent to disciplinary school.

Thus, silence seemed to be the chosen attitude of those who, once they allowed themselves to become involved in what was going on in the group, uttered rather harsh judgments. Hence, it may be assumed that

their initial inability to modulate affect might be the probable reason for their "all or none" attitudes. In some instances "modulation of aggression," that is a switch from an attacking aggressive attitude to a more reality oriented, sublimated one came about almost instantaneously in some of our articulate group members--obviously because the impact of listening and having others listen to what they just said made them modify their position. Thus, one member of the group talked about having been addressed as a "nigger" and went on saying that once she has gotten an education she will be able to call subordinate whites "whitey." Then she added that since by then she will be superior to many uneducated whites it might be enough for her to just think of them as "well, whitey!" without needing to actually use the term when addressing them.

While this first formulation seems to fit the most essential changes seen in some, initially passive patients (changes which, in a dynamic sense almost duplicate the early developmental schedule,) observation of both initial behavior and changed attitudes of some of our active, articulate adolescents pointed to the crucial significance of therapeutic intervention aimed at modification of their self-image.

Diagram 3 attempts to give a dynamic-economic formulation (on the basis of clinical material) of the genesis of self-image, its role in determining actual behavior, and offers a hypothesis regarding modifications in self-image on the basis of the observed.

Let us concern ourselves first with c (character disorder) and d (neurotic) type patients since those are the most likely candidates for group therapy. They share with the two "sicker" a (depressed)

and b (borderline psychotic) group what we regard as the "primary" ingredient of poor self-image: The kind of relationship between the "good" and the "bad" introject, in which the former is far outweighed by the latter. By the "good introject" we mean the hypothetical basis for self-affirmative, optimistic attitudes (I can; I will; I am basically OK, likeable, reasonably competent; next time, hopefully, I will do better, etc.) and by the "bad" introject the psychological basis for a depressed, pessimistic outlook, feelings of worthlessness and even a sense of futility (what's the use; who cares; I am no good; nobody loves me, etc.)

As you will notice on the diagram, in three of the four diagnostic groups I chose to present (arbitrarily!) a 1:2 ratio between the "good" and the "bad" introject, since on the basis of attitudes elicited in the initial evaluation and subsequent therapeutic processes I was impressed by this kind of similarity of predominantly negative basic attitudes toward the self with the undeniable presence of less conspicuous positive tendencies. What covers up this basic similarity and accounts for the variety of clinical behavior is an ego factor: The configuration of defenses.

Let us describe the "ideal" c (character disorder) patient as one who denies his need for real self-acceptance, and identifies with the "bad" (aggressive) introject, thus avoiding the greater psychological dangers of inertia, apathy (a group) or withdrawal from reality (b group). He will treat the world the way his "bad introject" treats his ego, and he can be sure, the world (his environment) will reciprocate by treating him just about the way his "bad" introject

always told him he ought to be treated: A good example of a self-fulfilling prophecy.

Our oversimplified d (neurotic) patient, however, denies that the ""bad" introject is, in fact, as punitive and vicious as it is (and as it will be found out to be in the course of therapy.) He identifies with (defensively takes over the role of) the "good" introject. Hungry and deprived as he is, his defenses help him out by manufacturing "diet cola" instead of milk or "paper gold" instead of the real stuff. However, this magician business is extremely costly because of its excessive drain on mental energies needed to cover up the real state of affairs, and while it allows him to claim: "I am accepted, competent, OK, etc." there is relatively little energy left to test it out and "prove it!"

The therapeutic intervention in both instances consists of (1) working through (to whatever degree) the defenses, which enables us to (2) lay bare (to whatever degree) the basic conflict between attitudes determined by the "good" and "bad" introject; (3) gradually, through the patient's introjection of the therapist's and fellow group members' positive attitudes toward him, the power balance between the "good" and "bad" introject is modified since the former increases and the latter decreases in strength; (4) subsequently the urgent need for certain, relatively primitive defenses (used to cover up a basically unbearable situation) subsides, ego activity can take place on a "higher," more realistic, more adaptive, hence more effective level.

In a psychodrama situation simulating a court hearing in the case of a group member who ran away from home (it was meant as a rehearsal

for the "real thing" which was to take place the next day!) although the girl who in reality ran away from home, played the role of the judge, she impulsively interrupted the "defense attorney" who just stated: "She ran away because her mother does not love her," and corrected the statement: "That is not true, my mother loves me, but she does not understand me." Up to then it was all: "I don't love her and she does not love me."

SUMMARY

It is presumed that passivity as well as destructive acting out behavior can be explained on the quasi identical basis of a predominantly negative self-image defended against by denial (either of the need for, or of loss of, gratification) and identification (either with the aggressive "bad" introject or with the weak "good" introject.) Therapeutic intervention aimed at strengthening the "good" introject, hence, at least indirectly, weakening the "bad" introject results in both qualitative changes (by modifying the defense configuration) and quantitative ones (liberation of mental energies which were hitherto unavailable for constructive purposes.)

As to etiological considerations regarding how the kind of (above discussed) poor self-image would come about, we can only offer some rather speculative ideas:

(1) We have no factual knowledge concerning the quality of actual early mothering experience in the case of our patients, hence what we detect as "good" and "bad" introjects need to be only recognized as the individual's perception of environmental (maternal) attitudes toward the self.

(2) While the kernel of the "good" and "bad" introject are formed early in life, the later environmental influences are presumed to greatly contribute to (reinforce or modify) the content and relative strength of the "bad" and "good" introject (hence the significance of therapeutic intervention.) Accordingly it is probable that an oppressive, restrictive environment might account for a general hypertrophy of the "bad" introject in the individuals thus affected. But, just the same, maternal attitudes, too, might be a major factor; (a)because of the mother's own continuous exposure to this environment's depressing influence as well as (b) because it might be deemed necessary from the point of view of reality adaptation to teach one's child to "know his place" in a segregated society and to be well aware that he is considered by others (which, as we know too well, might easily spell in terms of the psychological reality of the individual that he begins to consider himself) inferior.

Diagram 1 Improvement without change (i.e., without acquisition of new attitudes) consisting of increasing frequency of functioning on the higher rather than lower levels of the initial range of behavior.

Neurotic (character disorder) functioning

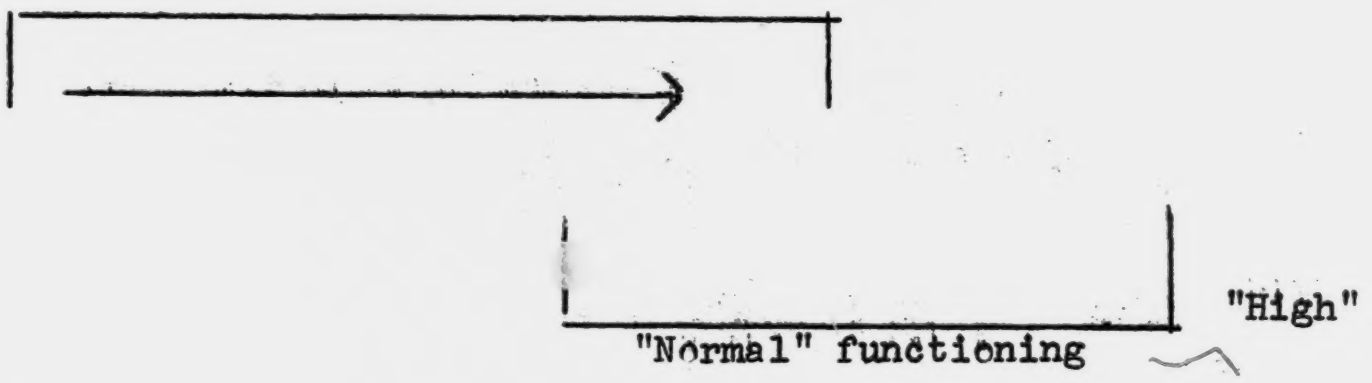


Diagram 2 Increasing level of activity with constructive aims.

CONSTRUCTIVE

orally dependent
clinging
inert - lethargic
"I can't"

competence-assertiveness
mastery-interest-exploration
creativity-synthesis-selectivity
(reality principle!)

PASSIVE ACTIVE

passive-aggressive:

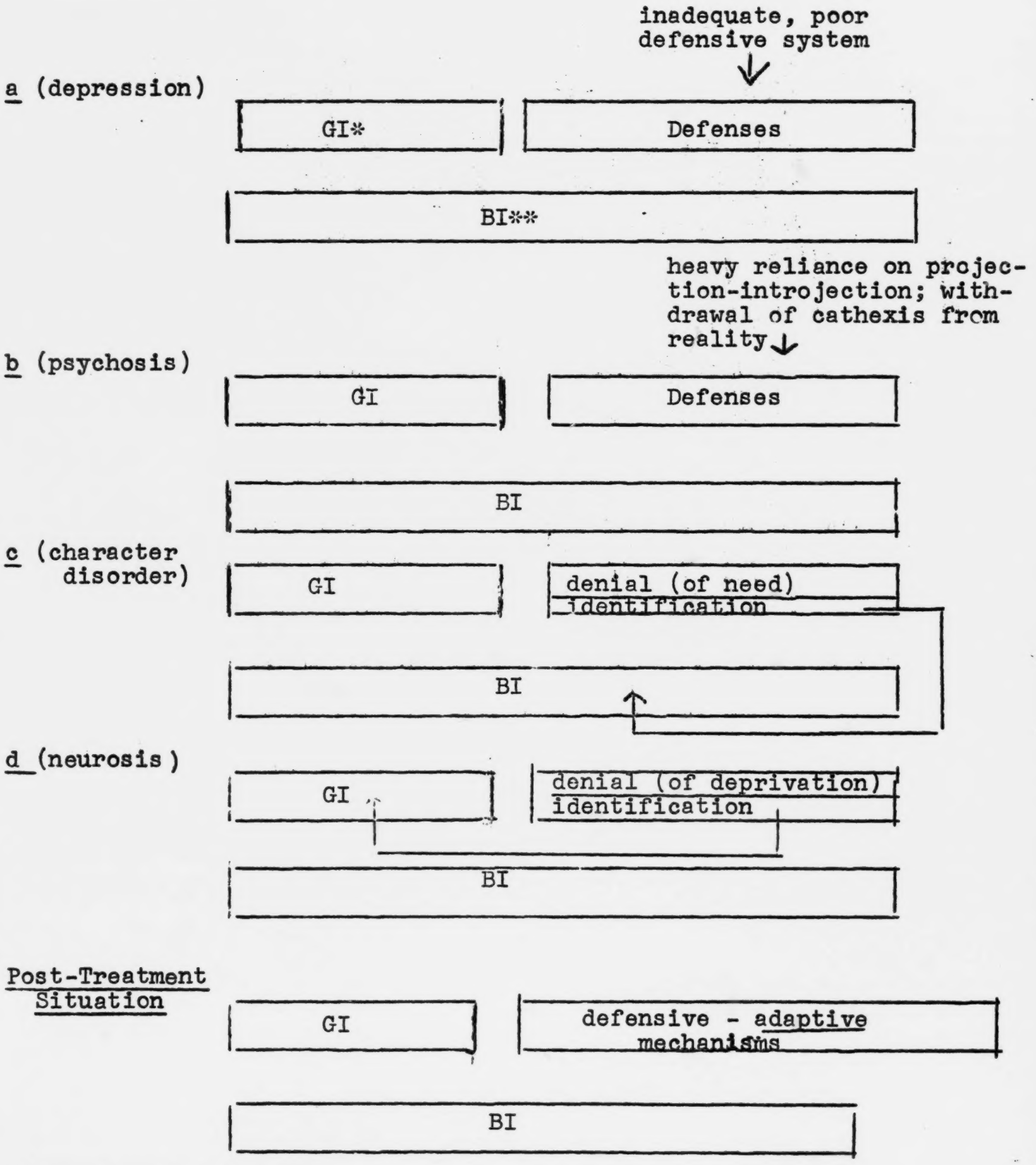
"I won't"
stubborn
submissive
"retentive"
self-defeating

oral
anal
phallic
aggressive :
demanding
controlling-imposing
"attacking"

DESTRUCTIVE

Diagram 3

Initial Position



*GI - "Good" Introject
**BI - "Bad" Introject